

# Guest Editorial

Ronda Henry-Tillman, MD and  
Paulette Mehta MD, MPH



## Breaking Down Barriers to Colorectal Cancer Screening

As the third most common cause of cancer-related death,<sup>1</sup> colorectal cancer (CRC) is a major public health problem in the United States today. The stage at which CRC is diagnosed has a significant impact on patient outcome, with later stages associated with high mortality despite the use of aggressive and costly treatments.

For this reason, routine CRC screening has been recommended for all individuals over age 50 (average-risk patients). Such screening has the potential to reveal precancerous lesions that may be removed immediately (primary prophylaxis) or to facilitate CRC diagnosis at an early, curable stage (secondary prophylaxis).<sup>2</sup> Yet, despite these clear benefits, only about 50% of eligible Americans are being screened.<sup>3</sup>

Why aren't more patients screened? Examinations have revealed multiple barriers to CRC screening, which involve patients, providers, and health care systems.<sup>4-6</sup> Of these barriers, the lack of encouragement on the part of providers is particularly troubling.<sup>7</sup> In many cases, such lack of encouragement may relate to a situation, described by Rothschild and Greaves in this issue (see "Colorectal Cancer Screening: VA Providers' Attitudes and Practices," on page 37), in which primary care providers do not routinely recommend their preferred

CRC screening method, colonoscopy, to average-risk patients because of a perceived—or real—lack of capacity within the health care system to perform such tests. While some providers respond to this lack of capacity by recommending screening through the less expensive and more readily available fecal occult blood test (FOBT), others do not because they do not believe FOBT offers the same screening value as colonoscopy.

Yet evidence supports a substantial and statistically significant reduction in colorectal cancer mortality with biennial FOBT.<sup>8</sup> Problems with FOBT's effectiveness usually arise from incorrect or inadequate test administration. Often, it is performed on a single stool specimen obtained in the office during a digital rectal exam, rather than on three spontaneously passed stool specimens obtained by the patient at home. And research has demonstrated a dramatic reduction in test accuracy (from 33% to 5%) when the single office-obtained sample is used in place of the three spontaneously passed samples.<sup>8,9</sup>

It is true that many regions of the United States—especially rural areas—have insufficient endoscopic capacity.<sup>10-12</sup> Several investigators have suggested ways to increase access to endoscopic screening, such as training more providers (including nurses) to perform endoscopic procedures, boosting the number of physicians who graduate from medical schools and the number of gastroenterologists in training programs, providing direct access to colonoscopy without referrals, and limiting colonoscopies to high risk populations or individuals who have had a positive FOBT result.<sup>13-15</sup> Each of these approaches holds the potential to

improve matching of colonoscopy need with the ability to provide the test.

Until the capacity problem is addressed directly, the situation is likely to worsen. CRC is a disease of advanced age, and both the veteran and general U.S. populations are aging. Insufficient screening of the increasing number of elderly individuals is likely to result in a higher incidence of late-stage disease, which goes hand-in-hand with human pain and suffering as well as increased treatment costs. Now is the time for health care systems—particularly the VHA—to take action to alleviate the capacity problem in order to fulfill current recommendations and give each patient the best possible chance of avoiding or overcoming CRC. ●

### Author disclosures

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**Dr. Henry-Tillman** is an associate professor in the departments of surgery and internal medicine at the University of Arkansas for Medical Sciences (UAMS), Little Rock. **Dr. Mehta** is a professor of hematology/oncology in the departments of internal medicine and pediatrics and a member of the Winthrop P. Rockefeller Cancer Institute's Cancer Disparity Program, both at the UAMS; a staff physician at the Central Arkansas Veterans Healthcare System, Little Rock; and a member of the *Federal Practitioner* Editorial Advisory Association.

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